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ABSTRACT

Based upon evaluations of 50 agencies as part of the Programmatic Research Project on the Rehabilitation of Homebound Persons, the booklet offers information for successfully administering homebound rehabilitation programs for handicapped individuals. Characteristics of New York's successful program are pointed out in the first chapter. Subsequent chapters cover the following: the home as a rehabilitation facility, administration of accessibility services, administrative steps to counteract limitations in the home, managing the program's impact on on-going relationships, family interference, the isolation component, dependence reinforcement in the home, the customary function of the home, administrative considerations relating to psychological responses of the professional worker, selecting an administrative route to homebound programing, the financing of homebound rehabilitation programs, and impact on future programing of the Rehabilitation Act of 1973. (SBH)

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THE ADMINISTRATION OF HOMEBOUND REHABILITATION PROGRAMS:

A MONOGRAPH OF THE PROGRAMMATIC RESEARCH PROJECT ON THE REHABILITATION OF HOMEBOUND PERSONS

BY: HERBERT RUSALEM, Ed.D.
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This Project was sponsored by Federation of the Handicapped, 211 West 14th Street, New York, New York, 10011 with the assistance of a Grant from the Social and Rehabilitation Service, U.S. Department of Health, Education and Welfare.

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The Programmatic Research Project on the Rehabilitation of Homebound Persons is one aspect of the comprehensive multi-function rehabilitation research offered by Federation of the Handicapped.

Among the Components of the Program are:

1. The Rehabilitation Learning Capacities Project
2. The Rehabilitation Disability Prevention Program
3. Higher Horizons for the Homebound
4. The High School Homebound Program
5. The Homebound Employment Program
6. The Homebound Recreation Service
7. The Tri-Eval Vocational Evaluation Center
8. The Training Services Program
9. The Counseling and Placement Service
10. The Rehabilitation Workshop
11. The Industrial Services Department
12. Personal Aides to the Homebound
13. The Research and Development Program, including the National Research Utilization Effort
14. The Advocacy and Community Education Program

Although Federation of the Handicapped is a Local Voluntary Non-Sectarian Agency, its Homebound, Learning Capacities, Disability Prevention, and Research Utilization Activities are national in significance.

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INTRODUCTION

MILTON COHEN
EXECUTIVE DIRECTOR
FEDERATION OF THE HANDICAPPED

The theory of the rehabilitation of homebound persons has outstripped everyday practice. Herb Rusalem has postulated this theory in the following terms:

1. The current vocational rehabilitation service structure is adequate for achieving the vocational rehabilitation of most homebound persons.

2. Yet, the large majority of homebound people in America do not have access to the vocational rehabilitation services that they need.

3. The reasons administrators offer for this service lag usually are the economics of the situation and the difficult problems presented by homebound clients.

4. Both of these rationalizations are open to question because rehabilitation agencies of all types are rehabilitating homebound persons without major difficulty day-in and day-out.

5. It is, therefore, theorized that the central barrier to the rehabilitation of the homebound is in the heads of rehabilitation administrators. Irrational negative attitudes and inadequate information abound and, in actuality, deny more than two million homebound Americans distributed access to these services that could render them more independent and self-sufficient.

6. The modification of attitudes is a very difficult challenge. Yet, given the fact that most rehabilitation administrators are gifted and reasonable people, they may well be influenced by means of cognitive dissonance. That is, if information contradicting their biases is presented forcefully and often enough, they may re-examine their beliefs and, hopefully, modify them in the direction of the facts.

7. In view of this, a central theory of homebound rehabilitation is that information will help. Repeated exposure to the facts of the situation should precipitate reversals in common administrative attitudes toward the homebound and accelerated movement toward more extensive homebound rehabilitation programming.

This Monograph is the third in a series issued by the Programmatic Research Project on the Rehabilitation of Homebound Persons sponsored by Federation of the Handicapped with the assistance of a Grant from the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare. The principal purpose of the series is to generate cognitive dissonance. Indeed, the information presented

should challenge the stated views of many administrators. Once this has been done, the way may be paved for changed administrator behaviors and strengthened resources for the homebound.

As part of this major attempt to modify thinking in the Field, this particular Monograph has special relevance in that it summarizes many of the findings and conclusions of this complex Project. In effect, it informs the reader about the "how" of homebound rehabilitation. In this regard, it is important to note that this material did not emerge from philosophical constructs of the theories of the Project staff. On the contrary, the materials offered in the pages that follow reflect successful practices in the Field and actual findings of the Project. Although no two homebound rehabilitation programs are identical and although the solutions developed in one community may have limited relevance for others, it was evident to the researchers on this Project that sufficient experience has been gained throughout the United States to offer guidance to agencies seeking to initiate or expand their homebound rehabilitation programs.

If this Monograph proves useful to some administrators in this connection, it will have fulfilled its purpose. In addition, it is important to note that Herb Rusalem and I, both of whom served as unpaid Project workers for more than seven years because of our commitment to the homebound, stand ready now, even though the Project has terminated, to assist any agency or rehabilitation worker in any matter concerning the homebound. Our hope is that you will use this Monograph and our offer of help to open new vistas for the homebound people of your community.

THE ADMINISTRATION OF HOMEBOUND REHABILITATION PROGRAMS

HERBERT RUSALEM and MILTON COHEN

More than two million Americans are so physically, intellectually, or emotionally limited that they cannot regularly participate in educational, vocational and social activities in the community with the aid of the transportation resources that are normally available to them. The Programmatic Research Project on the Rehabilitation of Homebound Persons (Rusalem, 1972) conducted by Federation of the Handicapped with the support of the Social and Rehabilitation Service clearly demonstrated two overarching facts about this vast group:

1. Fewer than 5% of the homebound group who can benefit from rehabilitation services are receiving such services.

2. Those who are receiving services benefit substantially from them and, in the process, require no major alterations in current rehabilitation practices to do so.

The central conclusion derived from seven years of research in this Project is that rehabilitation agency administrators constitute the single most impermeable barrier to independent living for homebound persons. This barrier is even greater in its effect upon homebound persons than the severity of the disabilities, the apathy of the community, and the expected difficulties that are encountered in delivering services to this group. Indeed, once an administrator decides that he has a responsibility for, and a committment to, the rehabilitation of homebound persons, forces are set in motion which almost immediately bring the rehabilitation of this group out of the realm of the impossible into arena of practical everyday service.

The conclusive evidence for this statement was derived from an intensive field study of 50 agencies offering differentiated homebound rehabilitation services. These agencies come in all sizes, shapes, and types; they cover the total spectrum of rehabilitation facilities in the United States, with only one major factor in common--they serve homebound people. When a comparison was drawn between these 50 agencies and 50 others that do not work with homebound persons, only one variable differentiated the two categories. Contrary to expectations, this variable was not fiscal status, the level of sophistication of the staff or the administration, the philosophy of the agency, the community in which the agency is located, its place in the community, nor the other types of rehabilitation programs which it offers. The one differentiating variable was an administrator who saw service to the homebound as the mission of his organization and who felt a personal committment to see to it that this mission was fulfilled.

Given this initial critical variable, all other obstacles to homebound rehabilitation programming were overcome. And, the obstacles are numerous. But, as demonstrated by the very ordinary agencies that are now regularly serving homebound clients without facing impending bankruptcy or disruption to their other programs, the problems are manageable. This Monograph will describe some of the techniques that administrators are using in everyday practice to cope with these problems. As a preliminary step, however, it is advisable to explore the argument that common garden-variety administrative procedures do succeed in making the rehabilitation of homebound persons a feasible rehabilitation enterprise.

The most persuasive data supporting Homebound Rehabilitation Programming emerges from the experience of state and other rehabilitation agencies that offered

for many years, defined homebound rehabilitation services. The prototype of these programs was developed during the years of the Great Depression of the 30's by courageous and far-seeing rehabilitation administrations in the State of Wisconsin. Concerned about the desperate situation of the homebound in that State and moved by the vision that they could be assisted, these administrators established the Wisconsin Homecrafters, a program that continues today to be one of the outstanding efforts of its type in the world. Interestingly, despite evidence of well over 30 years of experience in this Program, there still are state rehabilitation agency administrators who believe that it cannot or should not be done.

Among the other forward-looking states, New York currently offers a vigorous and dynamic homebound rehabilitation program that traces its roots back more than 20 years. On assessing this effort, it is well to keep in mind that the New York State Office of Vocational Rehabilitation is a typical state rehabilitation agency. It is in a constant struggle to fund its program properly; it has the customary personnel recruitment and training problems; it is coping with a vastly increased caseload of more complex rehabilitation problems; and it is affected by larger social and political movements in the State and Federal Government not all of which are consistently favorable to rehabilitation In short, it has nothing special going for it. On the contrary, those associated with the Agency might take the position that New York State has more than its share of rehabilitation challenges. Despite this, the New York State Office of Vocational Rehabilitation rehabilitates hundreds of homebound persons every year without special grants or other resources and without major alterations in the basic state rehabilitation agency structure and

process. Indeed, the rehabilitation of the homebound has become so commonplace at this Agency that it is almost taken for granted as much as the rehabilitation of leg amputees, the educable mentally retarded, or the cardiac.

How does New York State do it? In the early 1950's, an OVR administrator became concerned about homebound citizens in New York and resolved that steps should be systematically taken to bring these people under his Agency's service umbrella. Within a period of months, it was found that not only was the goal feasible but that it generated important side benefits for the community and the Agency, as well. Among these are: a reduction in the need for public assistance among members of the Homebound caseload, reduced economic and social pressure on the family, prevention of institutionalization, increases in Federal and State income tax payments, and general enrichment of the community.

An intensive Study by the Programmatic Research Project of the New York's OVR Homebound Rehabilitation experience produced the following fundings:

1. The rate of rehabilitation case closures achieved with homebound clients is comparable to that found in other OVR severe disability caseloads

2. The average cost of rehabilitating homebound people is only about $200. above the national average cost per rehabilitation closure. More important, this average cost was less than that of certain other disability groups that have been served by rehabilitation agencies for many decades, including the totally blind the paraplegic the disabled college student, and the double amputee.

3. The results of the New York State experience cannot be attributed to OVR cooperation with any single specialized agency. In this instance, only 25% of the homebound cases served were helped with the cooperation of Federation of the Handicapped which does have special homebound rehabilitation resources. In actual practice, more than 25 different community agencies actually participated in joint OVR programming for the homebound in a typical year.

4. Although the most evident advance made by these homebound clients was in relation to income, substantial other gains were observed, including improvement in family and institutional acceptance and adjustment, higher levels of self-care, enhanced intellectual and cognitive functioning, heightened self-awareness and self-regard, and greater involvement in community, home, and leisure activities. In almost every respect, these homebound persons were motivated to use the program effectively and constituted a fairly easy group with which to work.

5. Although considerable imagination, creativity, and involvement are required in homebound rehabilitation, unselected counselors on a state agency staff can function satisfactorily with homebound clients if properly oriented and trained. In practice, New York OVR assigns its counselors to homebound service without regard to their particular excellence or special attributes. While some are better than others in serving the homebound,

this is the case in regard to counselors working with any other caseload.

6. The rehabilitation outcomes of the New York State OVR Homebound Program tend to be long-term in nature. Follow-up studies conducted by the Programmatic Research Project of OVR homebound case closures revealed that most homebound clients retain their newly acquired jobs for years, even decades.

7. Perhaps, the most striking finding of all in this Study was that some 20% of the homebound cases served by the New York State OVR, became non-homebound in the course of rehabilitation. This was accomplished by the State Agency Counselors through physical and emotional restoration, lessening the impact of architectural barriers, and counseling and environmental adjustments that reduced psychosocial barriers to community participation.

8 Finally, it was found that the growth impetus of this homebound rehabilitation program has not lessened over the years. On the contrary, the homebound caseload is still expanding rehabilitation techniques are becoming evermore sophisticated; and cooperating community agencies are becoming more numerous and effective.

The central conclusion that can be drawn from the successful New York State OVR experience is that any other State Rehabilitation Agency that choose to do so can follow this model and, probably, can achieve similar outcomes. Indeed, several States already have followed New York's vanguard and others are on the verge of doing so. The key variable is whether a State Rehabilitation Agency administration has the will to do so. Similarly, among voluntary rehabilitation agencies, such organizations as Federation of the Handicapped, The Iowa Easter Seal Society The Missouri Easter Seal Society, The Texas Institute of Research and Rehabilitation, and many others are finding day after day that homebound rehabilitation is practical and that above all else, administrative resolve and resourcefulness are the mainsprings of service action for this group.

In order to make appropriate decisions in this area, rehabilitation administrators need information about the organization and operation of homebound rehabilitation programs so that their concern about such programs can be lessened through the impact of established facts. Unfortunately, until relatively recently such information was virtually unavailable. In a comprehensive review of the homebound rehabilitation literature, not too many years ago, Rusalem (1967) found few references that offered practical programming assistance to administrators and practitioners Today factual materials while not exactly abundant, are increasingly available from a growing number of sources. Uniformly these materials support the belief that homebound rehabilitation is viable in everyday agency practice Some of this information will be presented later in this Chapter. Before turning to it, however, it is important to examine still another major roadblock to program development in this area.

Among the rationalizations most frequently used to justify rehabilitation agency inaction on behalf of the homebound is the oft-made statement that the homebound have a low service priority. In these instances, priorities are used as an apparently socially acceptable explanation for widespread administrative exclusion of the members of this vast client group. This misuse of the priority concept throws the whole system of priorities into sharp relief. In positive terms, high priorities have benefitted such groups as the mentally retarded, the socially disadvantaged, welfare clients, and social security recipients, but not the homebound. In practice, homebound persons constitute a sizeable subgroup in each category, and, on that basis alone, merit first-order attention rather than exclusion from rehabilitation service. Indeed, they constitute a disproportionately high percentage of the public assistance clients, social security disability recipients, and disadvantaged subgroups. Despite this, the neglect of the homebound continued to be so shocking, that Congress felt it necessary to stipulate in the Rehabilitation Act of 1973 that service priorities should be re-ordered so that service to the severely disabled (including the homebound) will become a major concern of the Federal-State Rehabilitation Programs. This Congressional action, hopefully, will reverse the tendency of some State and Local Agency administrators systematically to exclude homebound citizens from the benefits of rehabilitation.

The use of the priority system as an exclusionary tactic has damaged thousands of homebound persons. Despite their skin-deep fact of infallibility, priorities are made by men and women who are as fallible as the rest of us. They bring to the priority-setting process their own biases and predilections and are influenced by compelling political and social pressures.

to make expedient judgements. Consequently, they are no more in a position to manipulate with peoples' lives than anyone else. Thus, the use of priorities to delay the initiation of rehabilitation services to eligible and feasible homebound persons or their unwarranted exclusion therefrom undermines the whole rehabilitation system. Historically, the central thrust of rehabilitation has been to eradicate discrimination against the handicapped. Paradoxically, rehabilitation priorities constitute discrimination in a highly pernicious form practiced by some who are quick to decry it in employers and other gatekeepers of our society. The humanistic concept that undergirds all rehabilitation is that if a disabled person meets the eligibility requirements for any public or voluntary program, any disqualification of that person on the basis of fallible and arbitrary priority rankings probably constitutes an infringement on his right to equal protection of the law. If such discrimination against the homebound (or any other rehabilitation group) continues, it will almost certainly be challenged in the courts. The Congress and our State Legislatures have keyed their enactments to the equal protection clause of the American Constitution. Government bureaucrats, Agency Administrators, and practitioners are no more immune from equal projection provisions in implementing rehabilitation programs than the legislators who created them. The growing advocacy movement, on behalf of the severely disabled undoubtedly will become increasingly reluctant to permit the human rights of homebound persons to be abridged by such arbitrary priority procedures and discriminatory judgements.

THE HOME AS A REHABILITATION FACILITY

An intensive investigation of 20 currently viable homebound rehabilitation programs (Rusalem, 1974) revealed that such programs rely heavily upon sound general administrative principles that apply to all organizational structures. In this context, sound homebound rehabilitation programs are characterized by well-designed fiscal controls, economical use of personnel and other resources, direct accountability from staff members, wide usage of techniques that benefit the maximum number of homebound persons at moderate cost, maintenance of parsimonious transportation arrangements and schedules, reliance upon direct lines of leadership, the adoption of sound cost accounting principles, effective production management, and the extensive use of community and family aids and resources. Beyond this administrative generalization, there one vital factor distinguishes all homebound programs and make them administratively unique. That is, the program is conducted primarily in the homes of severely disabled persons rather than in central or satellite locations. Thus, in homebound rehabilitation, there are as many separate rehabilitation facilities, workshops, or work activities centers to administer as there are homebound persons in an Agency's caseload. This proliferation of locations is, in and of itself, a sufficient challenge to rehabilitation administrators, but, complex as it is, it constitutes only one aspect of the administrator's problem in conducting a homebound rehabilitation program.

Another central problem is the special nature of a client's home ecology as a rehabilitation facility; including:

1. ACCESSIBILITY

Instead of relatively easily managed central sites, clients' homes are distributed over a broad geographical area often extending many miles beyond the Agency's headquarters and even its outreach stations. Although telephone communication is readily established whith these home sites (wherever a telephone is available in the client's home), face-to-face communication and the pick-up and delivery of materials requires a transportation arrangement of one kind or another. Indeed, it is axiomatic in this field that transportation constitute the most pervasive barrier to homebound persons and concurrently is the most difficult and costly administrative problem to manage.

2. HOME CONDITIONS

The design of rehabilitation facilities has become much more of a science in the past decade. In order to plan the construction or the renovation of such physical quarters, specialized architectural and social skills, understandings, and know-how are essential because it is evident that severely disabled persons require types of physical space and equipment that extend well beyond those found in industry or even in other community agencies. Yet, in relation to very limited homebound clients, a rehabilitation program is compelled to fit its program into a home setting which generally is deficient in terms of space, physical accessibility, special aids and equipment, and, not infrequently, containing dubious comfort. In some instances, the physical ecology of the home is found to be so

physically and emotionally deficient that it is impossible to conduct almost any type of rehabilitation service there. In some cases, even counseling services may be difficult to offer because privacy cannot be assured for interviewing. As far as a work program is concerned, a home setting often leaves much to be desired in the way work space, storage equipment, and separation from distractions.

3. IMPACT OF ONGOING RELATIONSHIPS

Every home is an arena in which complex and sensitive interpersonal relationships are played out. In some instances, these relationships facilitate the homebound rehabilitation program; in others they do not. Families use their homebound members to fulfill their own ends. In all too many cases, these responses benefit non-disabled family members more than they do the homebound person. Thus, family over-protection, overt and more subtle rejection, infantilization, or open aggression often swirl about the client and the rehabilitation worker as they attempt to work through critical disability problems. In a central facility, although the client does not fully escape the enervating effects of these relationships, at least he has counteracting interpersonal experiences while he is in the special center environment. Often, these center experiences provide an effective immunization of the disabled person against debilitating family behaviors which serve as an anchor upon which to establish more realistic and healthy self-perceptions. In the home, there rarely is such a counter-balance. As a consequence, both the client and the worker are enmeshed in emotionally charged situations over which

they have little control and which they well may vitiate the rehabilitation services delivered to the severely disabled person.

4. FAMILY OR COMMUNITY INTERFERENCE

Family members, neighbors, and even community agency staff members sometimes interject themselves into various aspects of homebound rehabilitation. Such interjection ranges from family members monopolizing the worker's attention when he visits the home, thus depriving the client of vitally needed professional time, to others doing the client's assigned remunerative homework for him. Since the rehabilitation worker is present in the home only occasionally and, then for very brief periods of time, agency control of local interferences is virtually impossible. Such interferences often appear to be well-meaning, but, in reality, they sometimes mask hostile impulses and aggression toward the severely handicapped person. The administrative challenge is to find means of preventing or limiting this type damaging behavior. Hopefully converting others in the home into contributing members of the rehabilitation service team.

5. THE ISOLATION COMPONENT

Interaction with peers is one of the principle dynamics of a rehabilitation facility program. Through getting feedback from other disabled persons and observing their rehabilitation struggles and successes, many rehabilitation clients are stimulated to work on their own problems and to seek their own solutions.

Indeed some rehabilitation facilities use successful present and former rehabilitation clients as role-models for newer clients. In this manner, fantasy elements in the self-concept, unreal expectations, and unwarranted despair are all reality-tested with one's contemporaries. In the home, however, the severely disabled client has few opportunities to reality-test his notions about himself and others and cannot readily share his rehabilitation experience with other disabled persons who may give him a quality of support and understanding that professional workers cannot provide. Thus, one of thecritical variables in rehabilitation service, that of group experiences, is absent in home millieu

6 DEPENDENCY REINFORCEMENT IN THE HOME

Most rehabilitation facilities consciously develop therapeutic environments which systematically reinforce personal, social, and vocational autonomy. Thus, the agency's physical setting, type of supervision offered, counseling approaches, reward systems, and reliance upon individual decision-making all contribute to the process of gradually enhancing client independence. On the other hand, such a therapeutic environment is infinitely more difficult to create in the home. Because of this, many relationships, physical features, family, activities and interpersonal attitudes in the home attenuate rather than expand personal self-direction. Not infrequently, these factors engender so much conflict on the part of the homebound client that he becomes paralyzed, being unable to follow-through on his rehabilitation plan despite his feeling some need to become more

autonomous. The challenge of this conflict and the causal reinforement of dependency in the family to the administrator is to find means of introducing program components into the home that foster greater client independence and self-sustenance in the face of such debelitative elements.

7. THE CUSTOMARY FUNCTION OF THE HOME

In our earlier history, the home was a focus for family educational and vocational activity and a place where a person's physical and mental health problems received personal attention. In those days of extended family nurturance, many jobs were performed in or near the home and, because it was possible for them to participate in such activities, fewer patients had to enter long-term hospitals and institutions. Home was where the action was; where essential life functions were carried on and where family members served each other in times of need. Today's nuclear family emphasizes other functions. Although, it still provides some emotional and social support and a certain amount of social activity, it is in many cases, only a kinship dormitory where food and clothing are provided by a breadwinner and some socialized behaviors are taught by example and direct instruction. In such a setting, home rehabilitation and employment may be intrusive and even unwelcome. Thus, the introduction of rehabilitation and work interventions into a severely disabled person's home can upset established routines and family concepts and arouse anxiety and uneasiness. Indeed, the administration of a homebound rehabilitation program often requires providing for family

counseling that, hopefully, will minimize such reactions. Otherwise, the home can become an antagonistic rather than a cooperative rehabilitation factor.

8 PSYCHOLOGICAL RESPONSE OF THE PROFESSIONAL WORKER

In its least virulent form, negative responses to homeboundedness on the part of professional workers are ideological in form. That is, the worker may have learned from leadership personnel and more experienced contemporaries that rehabilitation in the home, if it occurs at all, is infinitely difficult and frustrating. In this framework, the professional interjects into his professional thinking, the mythology that the home of a disabled person is an impossible rehabilitation setting. This mythology tenaciously reinforces aspects of the self that believe that rehabilitation cannot happen at home. Not infrequently, this ideology is cloaked with pious disclaimers of rejection of homebound clients and voluble protestation of belief in homebound rehabilitation programs. In fact, persuasive rationales often are offered by such workers to forestall their own anxiety and guilt. These rationales tend to be phrased in terms of presumed cost, inaccessibility of clients insuperable service problems, and now and then, by sonorous pontifications that no homebound persons live in a particular jurisdiction or that the few wh do live there are too aged, too feeble, or too poorly motivated to qualify for rehabilitation service. Since these rationales lack validity, there is some

suspicion that a proportion of rehabilitation workers are emotionally troubled by the homebound condition and, rather than face these feelings directly, some of them build a web of rationalizations to manage their inaction and avoidance. Just as certain disabilities arouse distress in some rehabilitation workers, so does homeboundedness trouble some of our colleauges. However, innocent or even unconscious that these feelings may be, their net effect is to exclude homebound persons from the rehabilitation services that they need.

If a homebound rehabilitation program is to be effective, the rehabilitation administrator will be required to manifest all the sound professional behaviors that mark good facilities administration. In general, however, in addition to providing leadership to the staff, the clients, and the community, setting a role-model for all concerned by reason of his committment to the homebound group, and orchestrating all program and management elements into an efficient approach to the problems of the homebound group, the rehabilitation administrator will have to find means of coping with the eight attributes of a home rehabilitation setting noted briefly above He will have to find some way of overcoming these limitations so that homebound rehabilitation becomes a feasible enterprise at his agency Listed below are a few of the approaches used by successful homebound programs in handling such troublesome elements. However, it should be kept in mind that no two agency situations use the same and that the solutions of one are not necessarily applicable to others. Thus, the suggestions presented are only illustrative in nature.

I. ADMINISTRATION OF ACCESSIBILITY SERVICES

Administrators of homebound rehabilitation programs have solved accessibility problems through two general means:

a. through bringing the homebound client to the service
b. through bringing the service to the home

A. BRINGING THE CLIENT TO THE SERVICE

When the physical movement of a homebound client to the rehabilitation facility is medically approved, logistically possible, and administratively economical, it has the irrefutable advantage of revising the homebound person's status so that he becomes a mobile rehabilitation client. This opens vast new rehabilitation opportunities for him that are beyond his reach as long as he remains homebound.

Bringing the homebound client out is most feasible in a compact geographical area where appropriate transportation facilities can be arranged and when clients are ready, willing, and able to leave their homes. Among the techniques used to transport such clients to the service facility are:

1. Agency-operated mini-buses or other transportation facilities that pick up homebound clients on a regular basis.

2. The use of volunteer drivers. Although this is the most economical approach, it is exceedingly difficult to maintain on an ongoing scheduled basis.

3 Taxicabs private contract drivers and on-call buses.

4. Movement of the client into a residence that is closer to the rehabilitation facility than his regular residence.

5. Developing foster or group home programs that bring the client into residences near the rehabilitation facility.

6. Conducting evaluation and training activities in a summer or year-round camp environment.

7 Housing clients in an intermediate care or long-term illness facility near the rehabilitation agency.

8. Developing car pools staffed by agency personnel and/or more mobile clients

9. Having the client participate regularly in agency-sponsored conference telephone calls that provide him with group experiences and group supervision.

10. Developing a paid core of poverty-area residents who, when provided with vehicles, assume responsibility for transporting homebound persons.

B. BRINGING THE SERVICE TO THE CLIENT

Very severe physical, intellectual, and emotional conditions, geographic inaccessibility, lack of emotional readiness to disengage oneself from the home situation, lack of transportation resources, and extreme family resistance may prevent regular attendance of the homebound client at central or outreach rehabilitation facilities. In these instances (perhaps, while efforts are being made to prepare the client as soon as possible to transfer into the established local facility) services will be brought to the client. These services usually include intake and evaluation, counseling, family guidance, socialization, personal adjustment and skills training, home employment, follow-up, and health care. Obviously, services delivered to the home are generally less comprehensive and systematic than in a rehabilitation facility but, still, infinitely superior to no service at all.

Among the techniques that have been used administratively to manage problems in this area have been:

1. The use of agency-owned or rented vehicles to transport agency staff members to clients' homes.

2. The use of public transportation to bring agency personnel goods, and services to the home. This approach has value in a limited number of cases in which public transportation is adequate and personnel time loss in traveling is not a crucial factor.

3. The use of messengers (such as mentally retarded clients) to deliver raw materials to, and pick up finished products from, the client's residence.

4. The employment of part-time local aides (perhaps qualified housewives) to bring goods and services to the homebound individual.

5. Using agency vehicles stationed at local "drops" or outreach stations that are closer to client's home than is the central agency facility.

6. Using United Parcel Service, Greyhound and Trailways Buses, and other public carriers to pick up and deliver merchandise at or near the client's home.

7. Using volunteer drivers to make deliveries.

8. Contracting with local trucking firms to make pick-ups and deliveries.

9. Having family members of the client take responsibility for merchandise deliveries.

10. Using trained and supervised poverty workers as homebound aides to bring both merchandise and services to the homebound individual (typified by the well-established PATH-Personal Aides to the Homebound Program conducted by Federation of the Handicapped.)

2. ADMINISTRATIVE STEPS TO COUNTERACT LIMITATIONS IN THE HOME

The initial step in this area is almost always a survey of the client's home to ascertain the nature of available resources and persistent problems, including family attitudes, financial status, transportation, readiness of neighbors to cooperate, architectural barriers, possible work space, recreation facilities, sanitation, ventilation, lighting and linkages between the home and the church, local health facilities, and social and fraternal organizations. Invariably, such a survey indicates that there are shortcomings as well as strengths in the home situation. The strengths are taken into account in planning home-based programs and the limitations become the subject of agency-initiated interventions. Throughout this procedure, every effort is made to alter the home both physically and psychosocially to expedite the rehabilitation of the homebound person. Among the steps that agencies have taken to strengthen the home environment are:

1. Family counseling around measures that the family can take to provide a healthier emotional climate for the homebound person.

2. Planning physical modification in space, attractiveness, sanitation, lighting, and

ventilation that will render the client more efficient and more comfortable.

3. Working with hospitals, health centers, physicians, and community organizations to create a more healthful environment for the client.

4. Working cooperatively with home economics specialists to redesign home activities and home organization so that the client can become as self-sufficient as possible in such activities as self-care mobility in and out of the home, and the use of home resources.

5. Assessing the possible impact upon the client's family of introducing remunerative work in the home and easing this impact, when necessary, by providing counseling and reassurance and by encouraging family participation in all phases of rehabilitation planning.

6. Working with welfare and other public and voluntary support agencies to equip the home with various appliances and devices that will foster client independence.

7. In the event that remunerative homework program is planned for a particular client cooperating with the State Rehabilitation Agency to provide the work tables, chairs, lamps, machines, and equipment needed to maximize client efficiency.

8. Developing clean-up procedures for the client and his family so that the space used for remunerative work can be converted to other family purposes when not being used for employment activities.

9. Evolving a suitable procedure for storing raw materials and finished products in the home so that the regular flow of family life is not disrupted.

10. Informing the family of the provisions of national, state, and local laws relating to homework and noting that violations of these provisions may result in discontinuance of all homework activity. Obviously, no amount of environmental modification will make a client's home equivalent to a rehabilitation facility. At best, even a soundly modified home millieu will contain numerous flaws and barriers but then the goal is not perfection. If the home can be made even moderately more suitable for rehabilitation activities despite residual limitations; this will constitute a major contribution to the client's rehabilitation. Administrators in the home-bound rehabilitation area should insist that their staffs make every possible move toward enriching the home environment but only after it has been clearly and unequivocally determined that rehabilitation in the home is the only viable rehabilitation alternative at the moment.

3. MANAGING THE PROGRAM'S IMPACT ON ON-GOING RELATIONSHIPS

The introduction of homework into a

homebound person's residence sometimes is perceived by some family members as an invasion of private life-space. In other situations, family members may view it as an attempt to wean the homebound person unwarrantedly away from his family or as a means of unjustified reducing his need to lean on family members. In some situations, families resent homework because it delays planned institutionalized or placement of the homebound person in some other out-of-home situation. In actual service experience, a whole gamut of family reactions may be expected to homebound rehabilitation efforts because such efforts upset the current balance of interpersonal forces in the home and however threatening than the consequences that may follow homebound rehabilitation. Agencies serving homebound persons have dealt with such family feelings in a number of ways:

a. Family members are involved in rehabilitation planning for the homebound client from the outset of service.

b. The family unit, rather than the disabled person, alone, is perceived by the rehabilitation worker as the client and rehabilitation or equivalent services are made available to all members of the group.

c. Rehabilitation plans are implemented very gradually so that drastic change does not occur too precipitously in the rehabilitation process.

d. Family members are assigned paraprofessional roles in the rehabilitation program, such as serving as assistant trainers, inspectors of finished work, and academic and vocational tutors.

e. Family counseling agencies in the community are invited to participate in the rehabilitation program established for a family unit.

f. Family counseling, rather than individual counseling, is made the fulcrum of the rehabilitation effort.

g. Carefully conducted planning with the family helps to set reasonable space and activity limits for the client's remunerative homework experiences.

In brief, although family participation is important in all rehabilitation programming, it is even more critical in the rehabilitation of homebound persons and, thus, it should be accorded special administrative consideration in formulating and implementing rehabilitation programming for this client group.

4. FAMILY INTERFERENCE

Professional entry of a rehabilitation worker into a homebound individual's home can be perceived by the family as a major social event or, conversely, as an invasion of family privacy. At either end of this scale or at any point in between, family and community members may behave in ways that deters the delivery of rehabilitation service. For example, family members may overwhelm the agency worker with hospitality, prevent the client from speaking for himself, use valuable time to instruct the agency worker about how to do his job, or engage in a variety of other activities that impede client progress. Equally serious are the attempts of some family members to discourage the client from participating in rehabilitation activities, underscoring the hopelessness of the pro-

posed rehabilitation efforts. Unless such behaviors can be prevented or remediated without delay, rehabilitation progress may be slowed or halted agencies offering homebound rehabilitation services manage these serious problems by:

a. Encouraging family involvement and counseling as noted in Section 3.

b. Offering as many rehabilitation services as possible outside the home.

c. Counseling the client concerning these interfering behaviors, hopefully enabling him to accept and use the proferred service despite other's negative views.

d. Enlisting the support and help of family physicians, visiting nurses, and other professional individuals who concurrently are serving the homebound person and his family.

e. Setting limits with the family and the neighbors indicating for them and the client the conditions under which service can be rendered and requiring all concerned to meet these standards for the sake of the client's ultimate rehabilitation.

f. If all else fails, discussing with the client the desirability and feasibility of relocating in a foster home or some other type of community residence. Deterrent family behaviors are difficult to control because they are firmly rooted in people's attitudinal structures. The most favorable administrative step that can be taken to forestall or minimize such behaviors is for administration to spell out clearly to the family, the client, and the

workers the conditions under which homebound rehabilitation service will be delivered. If these conditions are not met, efforts should be made through counseling casework, and other interventions to remedy the situation. Failing that, all participants should be made aware of the consequences of continued deterrent behaviors and; if necessary, rehabilitation service may be deferred until proper conditions for its delivery are established.

5. THE ISOLATION COMPONENT

Homebound people report that one of the most painful sequelae of homeboundedness is the monotony and boredom that fills their days. Many of these individuals turn on the television early in the day and detach themselves from it only for short periods of time until retiring in the evening. Almost invariably there just isn't enough for homebound people to do in the home. Empty hours follows empty hours and almost any break in the deadening routine is welcomed. The personal dread and despair that eventuates from this is not the only or even the most serious consequence of this situation. The fact is that prolonged deprivation, whether it be of essential life stimuli including interactions with others, engagement in useful and productive activity, and variations in daily routines reduce the responsivity, alertness, and motivation of the homebound individual. In time, this may result in cumulative disengagement from the environment and a cycle of progressive voluntary isolations that can lead to emotional blunting and ultimate institutionalization. Agencies serving the homebound use the following means to work with these isolation problems.

a If at all possible, the individual is taken out of the home, even if only once a week.

b. Volunteer or paid workers are regularly assigned to visit the client, provide companionship to him, share experiences with him, engage in recreation activities, and bring to him contact with the outside world.

c. Talking books on records and cassettes, are provided the homebound person so that he can enjoy the stimulation of the "printed" word in the form of oral communication.

d. If the homebound person is academically inclined, arrangements are made for him to take recorded or correspondence courses on a high school equivalency examination, or adult education level.

e The homebound person is involved in conference telephone discussion groups, adult courses, and group social conversations following the innovative telephone communications model pioneered by Federation of the Handicapped

f. Community volunteers, such as non-disabled members of a high school students homebound service corps are assigned to visit homebound persons and engage them in a variety of activities with them.

g. Homebound persons in a particular neighborhood are brought together in an outreach location, sometimes in the home of one of the group members, where informal social and educational programming can be conducted.

h. Home-to-Agency telephone service (comparable to home-to-school programs) are set up in which homebound persons participate in group programs conducted from agency premises through telephonic means.

i. Special vehicles are used to take homebound persons on trips in the community or, as in the case of Federation of the Handicapped even on foreign tours.

j. Special transportation is arranged on an occasional basis to bring homebound persons to special community or agency social or educational events.

In some instances, administrative provisions are made only for remunerative work. Although such programs are invaluable, they fill only part of the psychosocial needs of homebound individuals. Unless concommittant socialization programs are developed as well to reduce isolation, the rehabilitative outcomes of homework may be unjustifiedly limited.

6. DEPENDENCY REINFORCEMENT IN THE HOME

The central goal of homebound rehabilitation is to enhance client independence but the central goal of the client's family may be something else. Early in the homebound experience, the client has to establish a balance between his concurrent needs for both independence and dependence. Although this is a lifelong struggle for all of us, homebound individuals face many special in-home reinforcements, for the dependency aspects of their personalities. Indeed, family and friends often react to them in ways that reward helplessness and reinforce existing stereotypes.

Moved by pity, guilt, and oversolicitousness, family and friends often make it easy and pleasant to be dependent. Into this situation in which the dependence of the homebound person may be enshrined comes the rehabilitation worker, advocating greater independence. Understandably, universal joy and relief do not always accompany his offer of a better life for the disabled person. Given the family and community resistances that are likely to be stirred up by rehabilitation efforts, many a homebound rehabilitation plan has been sabotaged by family appeals to clients' dependency needs. Agencies serving the homebound have attempted to cope with these behaviors through the following means:

a. If it can be arranged, some or all of the rehabilitation program is conducted outside the home.

b. Family and client counseling are made essential components of the rehabilitation experience.

c. The rehabilitation worker consistently serves as a positive reinforcer of client behaviors that augur greater independence.

d. In treating the homebound client with respect and in requiring him to make his own decisions, the rehabilitation worker helps him to gain a new percept of himself as a person and sets a desirable role model for family members and others who relate to the client.

e. A specialist in self-care, life-skills, and/or home economics is assigned to train the homebound person to perform as many daily tasks for himself as possible. These training

activities are conducted with the approval and cooperation of medical and other health care personnel and have as their goal the demonstration of client capacities to do more for himself.

f. Family members and volunteers are trained in methods of fostering client independence.

g. Rehabilitation activities are assigned to the client in graduated sequences of small steps which virtually assure mastery of the tasks to be performed. This success experience is used as a positive reinforcer of client feeling of self-worth and self-reliance.

h. If the client enters a remunerative homework program, he is helped to use his earnings in a manner best calculated to improve his social status in the home. For example, his financial contributions to the support of the household, however moderate they may be, are useful as a lever in gaining respect from others, such as granting the homebound individual a larger role in family decision-making processes.

Independence is such a critical variable in determining whether a homebound rehabilitation program will be successful, that specific administrative planning for services in this area is essential.

7. THE CUSTOMARY FUNCTION OF THE HOME

The central problem in this regard occurs when remunerative homework becomes an ingredient of the rehabilitation plan. Many family members think that such work is incompatible with a home

situation and feels that it constitutes an infringement on their territoriality.

Understandably averse to having home space which they use for the other purposes allotted to work benches and tables, they react negatively to the use of closets or corners for the storage of materials; they object to the appearance of tools, equipment, and merchandise that are out in the open; and they deplore the apparent or imagined dirt, disorder, and clutter that they associate with work activities. Unless these feelings can be eased, the homework program tends to run into continuing family opposition. Thus, agencies serving the homebound use one or more of the following interventions to make homework more acceptable.

a. Homework items are kept as small, light, and unobtrusive as possible.

b. Wherever feasible, homework equipment is made portable and convertible. Preferably, work benches, chairs, and other equipment can be folded into compact packages and stored out of sight with little effort.

c. The client is taught to be orderly, neat and systematic in his work. He is instructed how to avoid clutter and to clean up work residuals when he finishes his daily job activities by re-ordering the work space even though this takes additional time and effort.

d. Joint planning with the family is conducted to select a functional work space in the home that will cause the least family disruption and distaste.

e. The homebound program staff works with the client and the family to engineer and design the work space so that it is as attractive and functional as possible.

f. As early as possible, family members are given an opportunity to discuss their feeling about the introduction of work tasks and materials into the home.

g. New work tasks are assigned to the homebound client only after they have been demonstrated to, and approved by, family members.

h. Regular pick-up and delivery schedules are maintained by the agency which do not allow an excessive quantity of work materials or finished products to accumulate in the home.

i. Periodic spot inspections of the homework area are conducted by the agency to ascertain if the client is functioning in the manner in which he trained and currently is maintaining the work area at a level that is tolerable to the family.

j. Insofar as possible, noisy, unsightly, and disturbing tools and equipment are avoided.

In addition to helping family members to deal with their feelings about remunerative homework, every administrative effort should be made to reduce the potency of work stimuli for generating family displeasure and resistance. Unless this is done, the family may discourage the homebound individual from participating in the program, causing premature withdrawal from the service and consequent unsuccessful case closure.

8. ADMINISTRATIVE CONSIDERATIONS RELATING TO PSYCHOLOGICAL RESPONSES OF THE PROFESSIONAL WORKER

Some administrators and clinicians offer few or no services for homebound persons, for reasons that are less than convincing in the light of current knowledge and experience. Undoubtedly, different clusters of personal and professional dynamics enter into this attitude among different administrators and workers. Among those that were identified by the Programmatic Research Project on the Rehabilitation of the Homebound Persons were Personal anxiety in the presence of homeboundedness the desire to play a stationary office-based (as opposed to an active field) role in one's professional life, avoidance of the presumed difficulty of rehabilitating homebound clients, lack of proper reward and reinforcement systems for serving the homebound, lack of previous experience in serving the homebound, fear of failure, and the inexorable pressures of the numbers game in which the quantity of rehabilitations is more important than the individual client.

Since the acceptance, energy, creativity, and warmth of the worker is crucial in the rehabilitation of homebound persons, the following administrative provisions have been made by agencies serving homebound individuals:

a. Only those rehabilitation workers who have demonstrated an affinity for homebound clients are assigned to these clients.

b. A special homebound service unit is established which specializes in working with severely disabled persons confined to their homes.

c. Agency leadership overtly and forcefully supports the homebound rehabilitation program and sets a model for the agency staff in unequivocally advocating the rights of homebound people.

d. Special reinforcements are offered to rehabilitation workers who serve the severely disabled.

e. Through supervision, reluctant and recalcitrant workers are helped to understand their feelings about the homebound and are given opportunities to work through their problems in delivering rehabilitation service to them.

f. Intensive training in the special techniques of serving homebound persons is provided to professional and non-professional workers throughout the agency.

g. Every appropriate agency worker and supervisor who is not emotionally threatened by the prospect is required to carry some homebound cases so that he can test his concepts about the group against the realities of everyday service.

h. Group sessions or "retreats" are conducted (often with the help of group dynamics specialists) at which staff members are encouraged to examine their feelings about homebound persons.

Whenever the above interventions fail to generate staff acceptance and elevate staff performance in relation to homebound clients, consideration should be given to the reassignment of personnel to other caseloads and to the possibility of disengaging such workers altogether from service to the severely disabled.

SELECTING AN ADMINISTRATIVE ROUTE TO HOMEBOUND PROGRAMMING

From an administrative viewpoint, it is wise to launch homebound rehabilitation programming on a small (even a pilot) scale using one of the tested models. Each of the following models has been used by one or more public and voluntary agencies as their preferred route to homebound programming. The selection of a model depends upon local needs, resources, and philosophies. None is intrinsically superior to the others, but, some are more appropriate than others for specified local conditions. The decision about which route a community should follow is one that can only be made by the agencies and groups concerned. Therefore, the material presented below is not meant to be prescriptive. On the contrary, it is merely a catalogue of presently-used homebound rehabilitation program models that may indicate to program planners the wide range of approaches that can be used in serving this population.

a. THE HEALTH CARE MODEL

This model was created in response to the finding that many homebound persons do not have ready access to medical, dental, nursing, physical and occupational therapy, and related health services. The consequences of this deprivation is the persistence and exacerbation of health conditions that generate and, in

cases, prolong homeboundedness. The central thrust of this model is to bring health personnel into the home through itinerant worker arrangements, mobile units, or local outreach stations.

As a result of improved health service delivery, some homebound persons have been rendered non-homebound and others have been helped to lead more comfortable and useful lives in the home and the community.

b. THE HOME ECONOMICS MODEL

Pioneered by Dr. Lois Schwab at the University of Nebraska and other home economics specialists, this approach views the home as a modifiable life ecology that can be enriched immeasurably for the improved person. The core goal is to improve the homebound individual's efficiency in his residence, not merely to augment the quality of living in the home, but wherever possible, to enable the homebound person to be less homebound and more active in his community.

Although home economists play a leading role in this service pattern, they do so in the framework of an inter-disciplinary team that takes a holistic view of the homebound individual and his problems.

c. THE RECREATION MODEL

This approach focuses upon the evident social deprivation suffered by many homebound persons and attempts to foster happier and more

useful living by training the person in leisure pursuits, providing recreational counseling, and involving him in carefully selected recreational activities. All these efforts are designed to make the world a more interesting place for the client, but equally important, long-range objectives are pursued in the areas of self-care, independence, emotional stability, interpersonal relationships, and ties to the community.

d. THE HOME AID MODEL

Home aid programming tecognizes the inability of many homebound persons to be fully self-sufficient in self-care and home management, even with training. For such persons, insitutuionalization often is an iminent and dreaded possibility. In order to forestall entry into congregate residences and the debilitation that may result therefrom this model shores up the person in his home, enabling him to remain there by assuring that he will receive essential personal care, live in sanitary and reasonably pleasant circumstances, be properly fed, and receive some degree of personal interest and nurturance. This service often is delivered to the homebound individual by trained paraprofessionals serving under skilled agency supervision.

e. THE INSTITUTIONAL MODEL

The Programmatic Research Project on the rehabilitation of homebound persons discovered that the negative effects of prolonged institutionalization derive not so much from congregate living under protective circumstances as upon the impoverishing nature of the man-

made environment that prevails in such institutions. While the institutional model accepts the inevitability of residential care, for some severely disabled persons, it tells that its deleterious effects are not inevitable. Thus, it seeks to enrich, extend, and humanize the residential millieu, converting it from a stultifying, impersonal and enervating environment into a dynamic, accepting, busy, and productive place where severely limited persons may develop, enjoy life, study, and even engage in remunerative work.

f. THE VOCATIONAL CRAFTS MODEL

In this model, homebound persons are taught to produce craft items for sale to others. Central planning, designing, instructional and supervisory services equip homebound individuals to make and market items that attract prospective purchasers. In an era when handmade goods are rare, such craft items have special appeal to a segment of the community despite the fact that their cost may be higher than comparable machine-made products. Craft items produced in this way are marketed by a central service conducted by the agency or by the sales efforts of the homebound person, himself, perhaps in cooperation with a profit-making or voluntary sales organization.

g. THE SELF-EMPLOYMENT MODEL

Participants in this model are trained to conduct small business enterprises from their homes in such fields as real estate, bookkeeping, secretarial and typing services, photocopying, keymaking and newspaper clippings. After

being trained in a particular field, the homebound person is helped to launch his private business and, then to proceed to develop it with continuing advice and guidance. In conducting his business, the homebound person operates just as any business entrepeneur would except for the fact that he does not routinely leave his work premises (that is, his home) to transact his business.

h. THE SUBCONTRACT MODEL

Usually associated with an ongoing sheltered workshop in the community, this model selects suitable workshop tasks for manufacture by homebound persons, instructs them in the performance of these tasks, provides them with raw materials, picks up finished products, and supervises the total productive effort. In a sense, the home becomes a sheltered workshop site which is governed by wages and hours regulations and other legal provisions, just any workshop is so regulated.

i. THE WORK ACTIVITY MODEL

Similar to the Subcontract Model, this approach places less stress upon productivity, manufacturing schedules, work pressures, and rigid quality standards. On the contrary, the work activities experience in the home is perceived more as a therapeutic than a career experience for the homebound person. In this respect, it is comparable to some recreation programs for the homebound, except that it deals with real work tasks and a reasonably realistic work environment. Remuneration for this work is modest with the experience having its greatest value as a means of keeping

vocationally-oriented persons who cannot qualify for workshop assignments busy, interested, and involved in a work enterprise.

j. THE CENTRAL OR OUTREACH WORK SITE MODEL

This type of vocational programming conducts few, if any, rehabilitation activities in the home. Instead, it makes every effort to transport homebound persons to the central facility or it provides residences in or near it. Having brought the person to the facility, the agency then administers the homebound client's program just as it would that of any other workshop client. The central problems in this model are developing a viable client transport system, arranging for nearby residences for homebound clients, and fostering client willingness and readiness to be brought out of the home, closer to the facility.

k. THE DIRECT EMPLOYER CONTACT MODEL

In this approach, homebound persons are evaluated and trained by the rehabilitation agency and helped to make contact with employers who are interested in hiring homebound workers. The decision to hire is made by the employer and, after the rehabilitation agency assists in the initial job adjustment of the homebound worker, subsequent work experiences are shaped by negotiations between the employer and the homebound person without the direct mediation of a third party agency.

l. THE MIXED MODEL

In this model, one or more of the above components are combined in a total homebound rehabilitation program. Such an arrangement, of course, multiplies both the opportunities for service and the administrative problems of homebound rehabilitation. On balance, it constitutes a vital development since no single program component or service model can in and of itself meet the needs of more than a fraction of all homebound persons. Through offering different routes to rehabilitation in a mixed model, agencies establish a situation that is more equivalent to that of other rehabilitation caseloads in that it offers options rather than a fixed unyielding stereotyped program.

m. THE COMPREHENSIVE MODEL

Still much more of an ideal than a realization, this approach offers as wide a gamut of services and opportunities for homebound persons as usually is offered to other clients. Thus, it includes elements of all or many of the models noted above. In such a program, it is possible to provide individualized rehabilitation planning for every homebound client so that his rehabilitation experiences are custom-designed to match his needs. Although one or two agencies such as Federation of the Handicapped are moving toward that goal, its ultimate realization is far down the pike.

The models described above do not exhaust the possible approaches available for the rehabilitation of homebound persons. Indeed, new ones are already on the drawing board and should emerge into the demonstration phase during the 1970's. Suffice it to say at this point, that even if rehabilitation were to be limited to the models described above, there is still much unfinished business awaiting us. Currently, only a few dozen rehabilitation agencies offer one, and even fewer offer two or more, of these alternatives to homebound clients.

Without generating further research and demonstration findings, there is still so much to be done that it would keep us busy for a long time to come. Indeed, the application of what we already know about homebound rehabilitation to actual programming will constitute a challenge for at least the next twenty to thirty years.

THE FINANCING OF HOMEBOUND REHABILITATION PROGRAMS

Although the costs of rehabilitating homebound persons are not as great as many rehabilitation administrators seem to believe, the fiscal aspects of the situation still merit extensive discussion. The most challenging fiscal condition usually arises after the rehabilitation phase of client service comes to a close. Until that time, reasonable state rehabilitation agency fees can be negotiated, that will cover some evaluation, training, equipment, transportation and rehabilitation costs. In this respect, it is fiscally desirable to arrange an evaluation and training time for the homebound individual of sufficient duration to allow ample opportunity to reach desired productivity levels. In view of the income needed from service fees, within the limits of reason and good rehabilitation agency practice, the longer

the period of state rehabilitation agency sponsorship the less will be the financial burden that ultimately falls upon the long-term service agency.

When service fees run out and the agency and the client stand fiscally naked and alone, reality begins to set in. In the first place, in having rehabilitated the homebound client under state rehabilitation agency auspices, the homebound service organization assumes an actual or implied responsibility to deliver long-term service to the individual in the post-rehabilitation period. In some instances, this responsibility can be diminished by placing the client with a private employer, obtaining the cooperation of one or more community agencies, or qualifying for special long-term workshop support grants as now are offered in a few states. In these instances, state funds are paid annually on a per client basis to agencies providing long-term workshop (or homebound) employment service in stipulated situations as an aid in defraying the cost of such programs.

In the long-run, however, post-rehabilitation homebound employment services will have to be supported by self-sustaining income derived from work activities and from philanthropic contributions. In the former instance, exceptional management skill is needed to negotiate fair prices for contracts and materials and to maintain program expenses at a reasonable level, thus assuring both the client and the workshop a satisfactory income. No businessman in private industry is ever faced with a more demanding administrative situation. By definition, homebound manpower is limited manpower, costly supportive services are essential; expensive transportation is needed; and suitable work for the home is hard to come by. Thus, it is a tribute to sagacity, professional maturity and talent of rehabilitation administrators that many of them are maintaining home-

bound employment programs at a solvent level. Some economies are possible through the recruitment and assignment of volunteers, the part-time use in homebound rehabilitation of staff members already engaged in other agency functions, combining homebound programming with other agency programming in scheduling transportation, obtaining family cooperation in the pick-up and delivery of materials, and pooling contracts between the agency's sheltered workshop and homework programs so that each can supplement the other.

Although funding problems have to be faced, they are by no means insuperable. Thus, Federation of the Handicapped and more than thirty other voluntary agencies have undertaken continuing responsibility for the employment of homebound persons over long periods of time without experiencing overwhelming economic strain. Indeed, administrators of homebound rehabilitation programs are astute and prudent managers as well as visionary leaders. None of them could afford to retain their homebound programs if, over the long-run these programs so seriously depleted agency resources that service to other groups was being impaired.

Most homebound rehabilitation programs initiated thus far in the United States survive; sometimes their continuous history goes back more than a generation (Wisconsin Homecrafters and Federation of the Handicapped). An examination of the stability of more recently developed programs suggests that few are experiencing serious financial trouble of such a character as to place the service in jeopardy.

THE ADMINISTRATOR LOOKS AHEAD

The Rehabilitation Act of 1973 emphasizes rehabilitation services for the severely disabled (including the homebound and the institutionalized). It is still too early to foresee the precise impact which this will have upon rehabilitation programming in the next five to ten years. However, a few informed estimates are possible at this time:

a. Building upon the impetus generated by the Programmatic Research Project for the Rehabilitation of Homebound Persons, the movement toward wider, more effective, and better-supported homebound rehabilitation programs will accelerate in all parts of the United States.

b. Existing homebound rehabilitation models will be used more extensively than ever as foundations for new programs, while adventuresome agencies at the outer edge will be exploring promising new leads and approaches that, in time, will become accepted rehabilitation practice.

c. Emerging advocacy programs will focus increasingly upon the severely disabled and, in the process, will call for strengthened homebound rehabilitation programs.

d. A growing number of cases in which rehabilitation services have been denied homebound persons will find their way into the courts and, as a result of the decisions reached in the judicial process, rehabilitation agencies will be mandated to serve homebound persons just as institutions now are being required by the courts to provide educational and rehabilitation services to their mentally retarded and emotional limited residents.

e. The mounting demand for more sophisticated homebound rehabilitation programs will sharpen the need for a national center (and, perhaps, concommitant regional ones, as well) that can perform the research, demonstration, and utilization activities that are needed to establish homebound services on a more scientific basis.

f. Administrators, practitioners, family members, and community leaders will need extensive training in the concepts and techniques of rehabilitating homebound persons. Consequently, both short, and long-term training programs will be established for this purpose.

g. Finally, and most important of all, a far larger proportion of the homebound people of America, currently neglected and exploited, will achieve a new and more functional status in our society and become taxpaying, contributing, and accepted members of their communities.

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UNIQUE SERVICES OF FEDERATION OF THE HANDICAPPED

1. LEARNING CAPACITIES

All rehabilitation requires disabled people to learn new concepts, behaviors, and responses. Despite this, very few rehabilitation agencies have developed sophistication in the learning areas.

Through its Learning Capacities Research Project, Federation demonstrated that failures in achieving rehabilitation objectives are often traceable to an incompatibility between a client's learning style and the instructional procedures used in the rehabilitation process.

This unique service:

a. Assesses clients' learning style through innovative evaluation procedures.

b. Prescribes evaluation and training procedures that harmonize with individual learning styles.

c. Develops materials and instructional procedures that fit atypical learning attributes.

This approach has value for all clients, but especially for the severely multi-handicapped clients with a history of learning failure, and those who are not achieving their potential in rehabilitation.

2. HOMEBOUND REHABILITATION

In an effort to demonstrate that homebound persons can be rehabilitated effectively within the boundaries of present-day legislation and practice, Federation of the Handicapped has developed and is conducting a complex of homebound rehabilitation services. These include:

1. Higher Horizons for the Homebound
   Using the findings of the Programmatic Research Project on the Rehabilitation of Homebound Persons as its base, this service applies innovative assessment, counseling, training, and placement service to the needs of persons who are so severely physically, mentally, and/or socially handicapped, that they cannot leave their homes regularly with available transportation to participate in rehabilitation, education, or employment activities.

2. Home Employment Service
   Provides hundreds of severely disabled persons with remunerative homework employment opportunities.

3. Personal Aides to the Homebound
   Trains and employs older persons to deliver selected services to homebound individuals.

4. Homebound Recreation Programs
   Provides a gamut of social and recreation activities to homebound persons who, otherwise, would be isolated in their homes.

5. Homebound Research Utilization Project
   Guides Agencies and Institutions throughout the United States in the development of

homebound rehabilitation programs.

6. High School Homebound Program
   A comprehensive vocational rehabilitation program for high school juniors and seniors who are on home instruction because of the severity of their disabilities.

3. PREVENTION OF PSYCHOSOCIAL DISABILITY

Many handicapping conditions are self-reinforcing by reason of family, community, and rehabilitation agency responses to disability. This unique emerging service is evolving procedures through which the progressive nature of handicapping conditions can be arrested, and even, reversed.

Among the prevention procedures currently under study are:

1. Early identification and intervention
2. Early introduction of vocational planning and remunerative work
3. In-patient hospital work programs
4. Transitional rehabilitation facilities interposed between institutional care and community participation
5. Vocational enrichment of institutional programs
6. Initiation of post-hospitalization in-home service for the non-homebound client

These studies are still in an early stage but already show promise as tools in the prevention of psychosocial disability.

4. PERSONAL ADJUSTMENT TRAINING

Using Learning Capacities and Tri-Eval findings, Counselors write a 25 period prescription(5 periods per day) for each client. This training prescription is composed of areas of functioning that relate specifically and directly to each client's needs. The selection and sequencing of areas is arranged differentially-but all areas are covered by a complete curriculum. Within each curriculum, definite lesson plans are scheduled daily. Among the areas represented are:

Group Counseling
Specialized Academic Subjects
Self-Care Training
Remedial Reading and Arithmetic
Manual Dexterity Training
Mobility Training
Clerical Training
Work Hardening
Workshop Training
Learning Capacities Training
Multi-Handicapped Group Training
Behavior Modification Training
Social Skills
Job Application
Speech and Personal Demeanor
Home and Family Life
Knowing Your Community - Knowing Yourself
Principles of Machine Operation
Practice in Following Directions
Household Skills
FED. Job Site Training
PATH Training-Porter Training-Messenger Training
Resocialization Training
High School Equivalency
Civil Service - Job Hunting
Money Management
Assembly Training - Packaging Training
Homemaking Training